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# NATIONAL GUIDE AND E-LEARNING MODULES FOR THE PREVENTION OF PSYCHOACTIVE SUBSTANCE USE IN MOROCCO

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**GOAL OF THE EXPERT CONTRIBUTION:** To assist in the preparation of a national guide focusing specifically on measures to prevent the use of psychoactive substances and an e-learning module geared to the situation in Morocco, to be used by civil society organisations and other stakeholders, targeting children between the ages of 12 and 16 at school and in the community, and their parents and wider family. Activities should be compatible with international standards and have proved their medium and long-term effectiveness and efficiency.

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## LIST OF ABBREVIATIONS

| | |
|---|---|
| **ICD (10, 11)** | International Classification of Diseases, versions 10 and 11 |
| **DELM** | Directorate of Epidemiology and Disease Prevention (*Direction de l'Epidémiologie et de la Lutte contre les Maladies*) – Ministry of Health |
| **DMNT** | Non-Communicable Diseases Division - DELM |
| **DP** | Population Directorate – Ministry of Health |
| **DSM-V** | Diagnostic and Statistical Manual of Mental Disorders, version 5 |
| **UNODC** | United Nations Office on Drugs and Crime |
| **WHO** | World Health Organization |
| **CSOs** | Civil society organisations |
| **PNPTA** | National Programme for the Prevention and Treatment of Addictive Disorders |
| **OMDA** | Moroccan National Observatory on Drugs and Drug Addiction |

## FOREWORD

Preventing the use of psychoactive substances in particular and addictive behaviour in general is one of the priorities of the Moroccan Ministry of Health. Promoting mental health and preventing addictive disorders among vulnerable populations are among the strategic aims of the national programme for the prevention and treatment of addictive disorders for 2018-2020. It is now recognised that broad-scale awareness-raising measures such as moralising messages are ineffective. Hence the benefits of running specific campaigns targeting populations at risk and/or in vulnerable circumstances with the aim of preventing addictive behaviours or at least of delaying their onset.

For several years, interest in validating operating models based on global scientific evidence has been steadily increasing. By pooling experience and evaluating prevention programmes and measures it has been possible to highlight which tools and approaches are the most effective and which are the least. It is now recognised that effectiveness depends among other things on how specific the measure is, how suited it is to the target population, what tools are used and how long the measure is applied.

In Morocco, associations working to promote public health in general and prevent disorders linked to substance use and addictive behaviours in particular are especially diverse and active. Although several of them work with children, adolescents and young people in vulnerable circumstances and have been able over time to build up unquestionable skills in grassroots community work, it is rare for their members to have been given specific training. Training material and national guides on setting up, supervising and assessing specific programmes in this field are completely lacking.

Recognising the importance of making such tools available, the Ministry of Health has decided to draw up a practical guide for use by CSOs and other stakeholders and professionals working with young people and at-risk populations. This national reference guide, which draws on the scientific evidence, will make it possible to implement coherent programmes to prevent psychoactive substance use and addictive behaviours geared to the national context and to assess their long-term effectiveness and impact. In line with the priority action areas identified, the guide is designed to meet the needs of children between 12 and 16 at school and in the community and their parents and wider family. Its presentation as a training module on paper and as an e-learning module makes it a practical tool to build the capacities of the stakeholders involved in preventing psychoactive substance use disorders and addictive behaviours.

***Dr Youbi Mohammed***
***Director of Epidemiology and Disease Prevention***

# I. INTRODUCTION

## A. THE EPIDEMIOLOGICAL SITUATION WITH REGARD TO GLOBAL PSYCHOACTIVE SUBSTANCE USE

On a global level, according to the UNODC world report on drugs of 2019, 35 million people were suffering from drug-use-related disorders and needed treatment in 2017 (compared to a previous estimate of 30.5 million). The number of deaths as a result of drug use was also higher than previously estimated, at 585 000. Prevention and treatment are still far from meeting needs in many regions of the world.

The same report states that in 2017, 271 million people, or 5% of the world population between the ages of 15 and 64, had used drugs in the previous year. Although this figure is similar to the estimate for 2016, looking at the picture over a longer term reveals that the number of people who use drugs is now 30% higher than in 2009, when 210 million people had used drugs in the previous year. Some 53.4 million people in the world had used opioids in the previous year, or 56% more than the estimate for 2016. Of these, 29.2 million had used opiates such as heroin or opium, or 50% more than the estimate for 2016 of 19.4 million.

## B. THE EPIDEMIOLOGICAL SITUATION WITH REGARD TO PSYCHOACTIVE SUBSTANCE USE IN MOROCCO

Drug use in Morocco is acknowledged to be a growing public health problem, affecting all social categories. Psychoactive substance use is increasingly prevalent among young people and is becoming commonplace among this section of the population, with harmful consequences at an age when the brain is still developing. Addictive behaviours arise from the interaction of a wide range of biological, psychological, economic, social, environmental and family factors.

Alongside the results of the national survey of all people over the age of 15 conducted by the Ministry of Health in 2005, which showed that 4.1% of the population had used psychoactive substances in the previous 12 months, MedSPAD surveys conducted at national level among schoolchildren confirm that ages of first use are decreasing and the range of knowledge and experimentation is increasing (vis-à-vis tobacco, alcohol, medicines and illicit substances).

In particular, the 2017 MedSPAD survey on schoolchildren between the ages of 15 and 17 highlighted the following prevalence rates:

- In 2017, 16%, or n=1101, said that they had smoked at least one cigarette in their life and 9% (n=602) said that they had done so over the preceding 12 months. There is a significant difference between the sexes where it comes to smoking cigarettes, with tobacco use higher among boys ($p < 0.0001$). Tobacco is also the psychoactive substance for which experimentation occurs earliest among 15 to 17-year-old pupils (14.3 ± 1.7 years). Other forms of tobacco use reported by the pupils surveyed were the use of shishas (water pipes), or tobacco to be sniffed (nafha) or chewed (kala).

- 6% of 15 to 17-year-olds, a majority boys, said that they had experimented with alcohol.

- 3% (n=114) had smoked cannabis over the last thirty days and more than three out of ten of the pupils questioned (30.3%) said that they had done so at least once. The gap between the sexes was wide and widened as frequency increased.

- In the same age bracket (15-17), 4% of the pupils questioned (n= 153) said that they had used psychotropic substances without medical advice or a prescription in the course of their lifetime. Prevalence figures were not influenced by gender. However, statistically significant correlations ($p < 0.001$) were found between substance use and absenteeism from school, an average mark below the class average in the previous term, nights spent away from home, having a family member or friend who uses drugs, being unfamiliar with the law against drug use, being able to obtain drugs easily, and failing to perceive the serious danger involved in drug use.

- The lifetime prevalence rate for cocaine use was 2% for boys and 0.8% for girls. For crack the rate was 1.4% for boys and 0.2% for girls. Statistically significant correlations ($p < 0.001$) were found between cocaine and/or crack use and absenteeism from school, an average mark below the class average in the previous term, nights spent away from home, having a family member or friend who uses drugs, being unfamiliar with the law against drug use, being able to obtain drugs easily, and failing to perceive the serious danger involved in drug use.

- For heroin, the lifetime prevalence rate was 0.77% (n=28). 0.71% (n=25) of all the pupils questioned had used cocaine over the last twelve months and 0.2% (n=7) over the last thirty days.

- The lifetime prevalence rate for the use of inhalants was 0.18% (n=10).

- Of all the 15 to 17-year-olds, 3.3% (n=118) reported that they had used other psychoactive substances. The other substances reported included Ecstasy, “Levure”, Domino and Extra.

- Of the 3 698 pupils between the ages of 15 and 17 questioned, 26.5% (n=979) said that they had used at least one type of psychoactive substance during their lives. Those who had tried a single psychoactive substance during their life amounted to 11.6% (n=430) of the total. 4.9% (n=181) had tried two substances and 3.6% (n=134) three substances. 2.1% (n=79) of pupils aged 15 to 17 had tried four substances and 1.7% (n=63) had used more than five.

The prevalence figures also showed that substance use was most widespread among boys and that preferences for substances varied according to gender. Tobacco was the most-used substance in the sample, followed by cannabis, then alcohol, then, in the case of boys, psychotropic substances. Girls used psychotropic substances more than they used cannabis. Cocaine, crack and heroin were still little used. Among this population of younger users, drugs freely available over the counter and those which were easiest to obtain were the most used substances (tobacco, alcohol, cannabis and psychotropic substances).

In addition, an overall analysis of drug use by Moroccan upper secondary school pupils highlighted a number of risk factors, of which the following three were crucial: the ease of access to drugs, which are often sold in the vicinity of schools; the trivialisation of drug use; and the lack of tailored, assessed and ongoing country-wide prevention programmes. Likewise, the failure to comply with the legislation prohibiting the sale of tobacco to minors and the ease of supply may be a further factor facilitating access for young people to tobacco, alcohol and other drugs. Tightening up the legislation may be a worthwhile step. For instance, setting up tobacco and drug-free zones around schools, placing an age limit on the supply of tobacco and alcohol, and prohibiting the sale of all

types of drug to minors may reduce the extent to which young people are introduced to substance use. The application of legislation against retail tobacco sellers could also limit early exposure.

# II. MAIN REFERENCE POINTS: FROM HEALTH TO ADDICTIONS, DEFINITIONS AND KEY CONCEPTS

The aim of this first section is to provide a common base in terms of definitions and key concepts in the spheres of public health promotion, addictions and prevention.

## A. PROMOTING HEALTH:

### II.A.1 The WHO definition of health:

According to WHO, health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".
An individual's health does not depend solely on his or her individual choices but also on many other factors such as the environment, living conditions and biological factors.

### II.A.2 Health promotion according to the Ottawa Charter:

On 21 November 1986, the First International Conference on Health Promotion, meeting in Ottawa, adopted a Charter intended to help achieve health objectives for the year 2000 and beyond.

According to the Ottawa Charter, health promotion is the process of enabling people to increase control over, and to improve, their health.

This approach derives from a concept defining "health" as the extent to which a group or an individual can on the one hand, realise its aspirations and satisfy its needs and on the other, change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living.

## B. DETERMINANTS OF HEALTH

The determinants of an individual's health can be divided into four main categories:
- **Human biology:** genetic factors, physiological factors, factors linked to maturing and ageing;
- **The physical, psychological and social environment;**
- **Behaviour, lifestyle:** occupational factors, leisure-related factors, consumption habits (food, toxic substances);
- **Organisation of health services:** prevention, curative care, re-education, rehabilitation.

**All of these factors are interdependent. The factors which influence health are multiple and interactive.**

***Source:*** *Chauvin F et al. Du bon usage de la communication en éducation pour la santé* (The proper use of communication in education for health)
*Proceedings of the Bierville International Seminar. Paris: Éditions CFES, 1998: 289 pp. Nutbeam D, WHO. Health Promotion Glossary. World Health Organization, 1998: 25 pp.*

Accordingly, health promotion relates both to individuals' behaviour in the health sphere and their lifestyles and to factors such as income and social standing, education, employment and living conditions, access to appropriate health services and physical environments.

Through their interaction and their combined effects, these factors create varying living conditions which have an impact on health.

All changes in lifestyle and living conditions are regarded as intermediate results in terms of health.

It is wise therefore to integrate health education into any approach to health promotion.

Health promotion is a positive concept emphasising social and personal resources, along with physical capacities. Health promotion is not just the responsibility of the health or care sector. It goes beyond healthy lifestyles and attempts to foster physical, mental and social well-being.

## C. THE LEARNING ASPECT OF HEALTH EDUCATION

WHO defines health education as an array of measures capable of helping individuals and groups to adopt healthy behaviour.

Health education is not confined to information about health, it provides individuals with the knowledge, know-how and life skills they need to be able, if they so wish, to change their behaviour or reinforce forms of behaviour that foster their own good health and that of their community.

Health is regarded as a resource for everyday life. It is for individuals to make responsible choices, to determine what is best for them and to strike the right balance.

There are three main co-existing approaches in health education:

- the injunctive or persuasive approach, whose aim is the systematic alteration of individual or group behaviour;
- the informative, empowering approach, whose aim is to make individuals aware of what is good for them;
- the participatory approach, whose aim is to foster the involvement and participation of individuals and groups in efforts to improve the supervision of their health.

**The goal is for individuals to acquire:**

**- knowledge:** a range of information assimilated by the individual. For example, knowledge about the effects of a substance they are using.

**- know-how (or practices):** practices or capacities to act or to perform a task. This may not be linked to knowledge. It is possible to know how to do something without knowing why it works (empirical know-how) and it is possible to know without knowing how (knowing in theory how to perform a task but never having actually done so and being incapable of doing so). For example, knowing how to use a breathalyser or a condom;

**- approaches to life (or attitudes):** the habitual and generally rather settled ways in which individuals perceive, experience and judge their own and others' actions and ideas, and their

social and physical environment. Attitudes govern perception and action. They have emotional, cognitive and behavioural components and are, for the most part, socially determined. One of the major goals of health education and health promotion measures is to change attitudes which are barriers to healthier lifestyles or a healthier policy.
Work on approaches to life can also be conducted through the development of psychosocial skills. For example: knowing how to refuse one's first cigarette.

***Source:*** *European Commission, Rusch E (ed.). European public health glossary*

# III. ADDICTIONS: DEFINITIONS, CLASSIFICATIONS, CHARACTERISTICS AND ETIOPATHOGENESIS

## A. ADDICTION: WHAT IS IT?

Addiction is a chronic brain disease, characterised by the appearance of relapses (which are the rule) and interfering with a series of internal and external factors. The disease gives rise to distortions of thinking, emotions and perceptions, which prompt people to behave in ways that their entourage cannot understand. Addictive behaviours supplant "healthy" behaviours; they are a manifestation of the disease, not its cause.

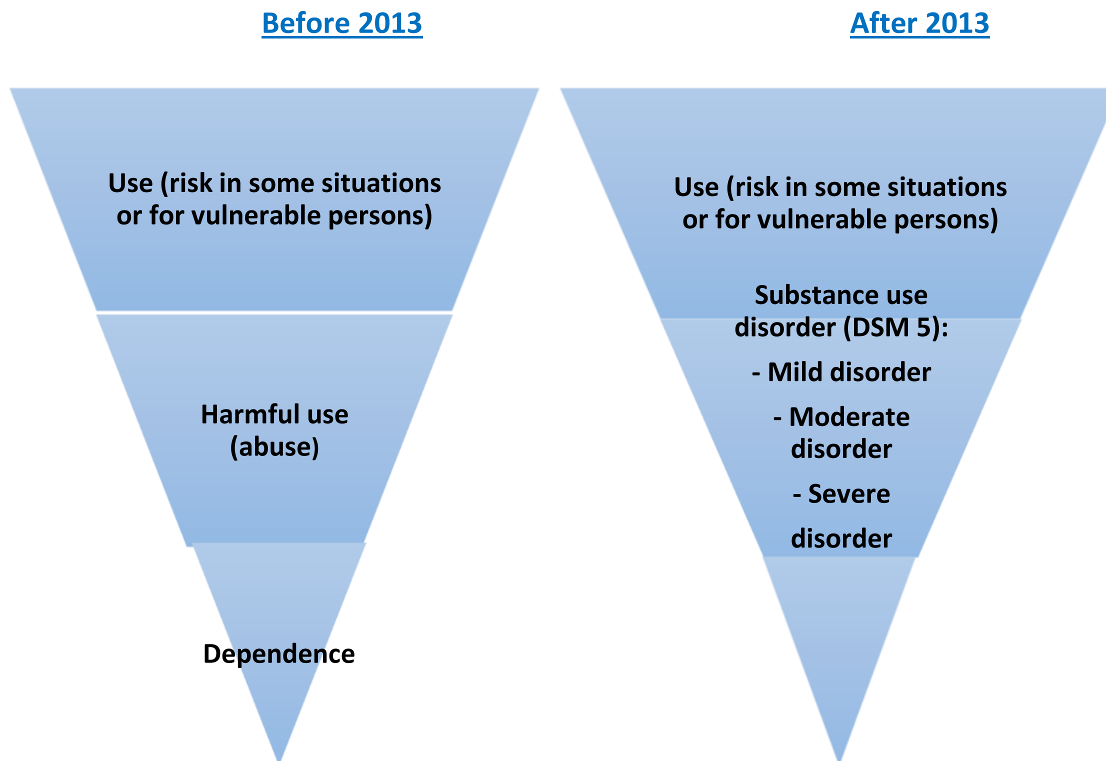
In other words, addiction is not a choice, it is a disease.

Addiction is characterised by:

- repeated inability to control behaviour engaged in to produce pleasure or to remove an internal feeling of unease;
- continuing to behave in this way despite being aware of the adverse consequences;
- a "chronic brain condition with relapses" requiring medical and psychosocial treatment.

The transition, in the early 2000s, from the notion of drug dependence and alcoholism to that of addiction profoundly altered our ways of thinking about the treatment and organisation of care for these disorders. We moved from a mindset which placed the emphasis on the product to one which focused on user behaviour and the setting in which this behaviour took place.

Since 2013, DSM 5 has taken the diagnoses of substance abuse and substance dependence, formerly defined separately in DSM-IV, and combined them under the single heading of "substance use disorders"; reiterated that recurrent legal problems are a criterion for substance abuse; added a new criterion of craving or a strong desire or urge to use a substance; added diagnoses for cannabis and caffeine withdrawal; and included pathological gambling (which was covered in DSM-IV under the heading "impulse-control disorders").




Today, "addictive behaviours" is used to designate a set of uses liable (or not) to result in a disorder.

There are also addictions which do not involve a drug or a substance, which are referred to as behavioural addictions.

## B. ADDICTIONS WITHOUT DRUGS, OR BEHAVIOURAL ADDICTIONS

Some individuals engage in behaviour which is reminiscent of dependent persons when faced with their drugs: for example conduct vis-à-vis sex, gambling, sport, food, work, shopping or new technologies (video games, mobile phones, the Internet, etc.).

The aim of these behaviours is to acquire pleasure and relief, though they need not be pathological. The concept of behavioural addiction will only apply if the person feels more of a true need than just a desire for the object by which they are fascinated and they persist in their behaviour despite any adverse effects this has on their social or affective life or their health.

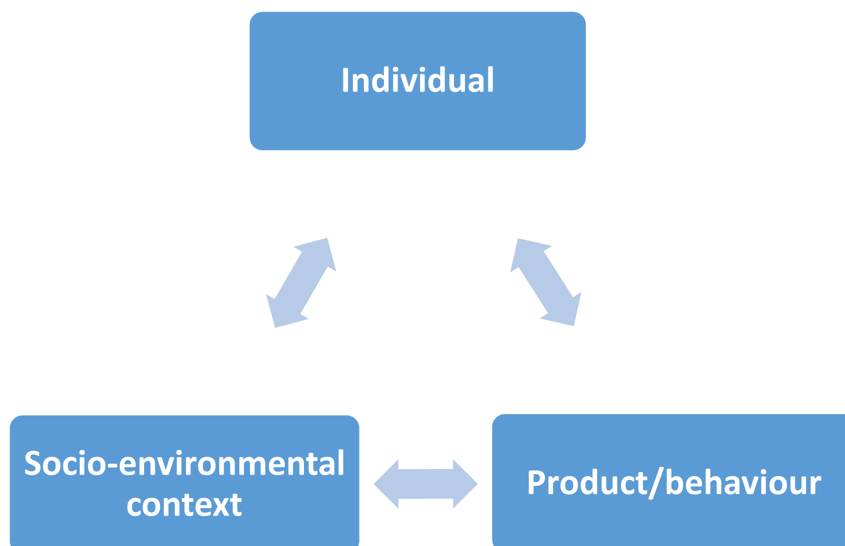
**Without claiming to be exhaustive, we can cite some of the main behavioural addictions:**

**- pathological gambling (addiction to games of chance and betting);**
**- compulsive buying disorder;**
**- addiction to sport and physical exercise;**
**- sexual addiction;**
**- pathological work;**
**- eating disorders;**
**- Internet addiction disorder …**

***Source:*** *Traité d'addictologie* (A Treatise on Addictology). *Edited by Michel REYNAUD. Paris, Flammarion, 2006 (Médecine-Sciences)*

## C. WHAT ARE THE FEATURES OF ADDICTIVE DISORDERS?

The criteria used for the definition of addiction clearly show that it is not the product which defines addiction but the relationship that the individual has with the product in its social and environmental context. This is the three-variable model, or the interaction between "a person, a product and a socio-cultural moment".




Addiction therefore is the outcome of the interaction between several factors, on which action needs to be taken:

• **Product-related risk factors:** specific dangers, means of administration, duration, frequency, quantities absorbed, interaction between substances.
• **Individual factors of vulnerability:** biological factors, psychological factors, expectations vis-à-vis the product, lifestyle, self-esteem, interpersonal skills.
• **Environmental risk factors:** social and cultural factors, family background, host environments (school work, friends), factors of economic vulnerability (poverty, financial insecurity), bad town planning and availability of the product.

The interactions between these factors give rise to differing forms of behaviour, whose effects can vary from one individual to another.

# IV. ADDICTION PREVENTION:

## A. DEFINITION:

Prevention is the range of activities or programmes which are designed to prevent the emergence, spread or aggravation of illnesses or disabilities (WHO).

Addiction prevention is currently undergoing major changes, adopting approaches based on academic research in the fields of sociology, psychology, health promotion and neurosciences. Structured programmes to enhance psychosocial skills are being promoted in national and international literature. These advances call on prevention practitioners, professionals in contact with young people and financial backers to make often radical changes to their practices.
Whereas it used to be standard to engage in ad hoc activities, run solely by prevention professionals, this approach is no longer recommended as it is thought to be ineffective. The idea that prevention could not harm its target audience was very widespread. It is now acknowledged that measures which are not geared to the target audience can be counterproductive or even have harmful effects.

Lastly, for a very long time measures were devised according to the substance being taken. It is now recommended to take account of the position of people in their context (school, family, recreation) and to introduce issues of substance use gradually.
The view of prevention of addictive behaviours as a comprehensive approach, not just simply as a series of unconnected activities, allows us to move away from mere service provision to joint projects involving stakeholders, prevention workers and financial backers.

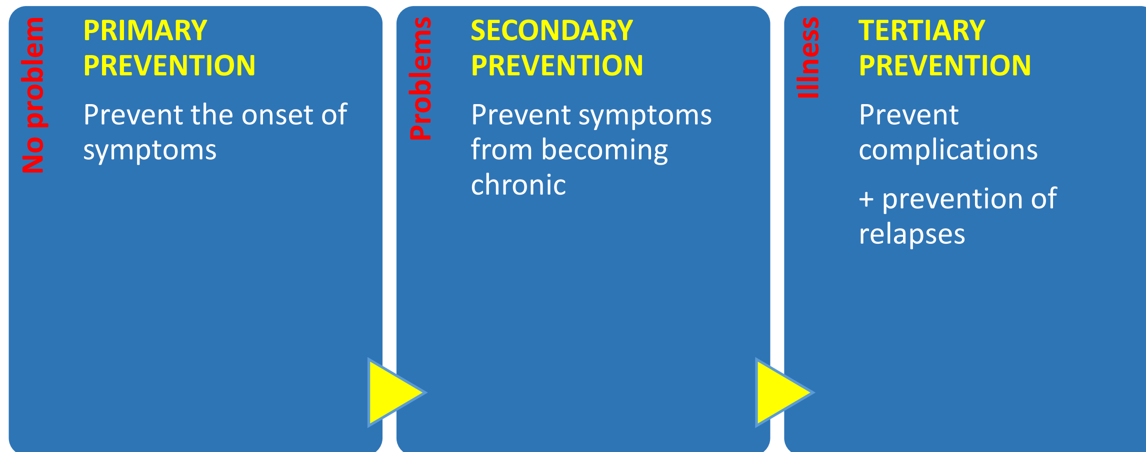
Prevention of addictive behaviours is intended to help every single young person to gain gradual access to means of making choices and adopting responsible behaviour, for themselves, for others and for the environment.

It makes it possible to prepare them to exercise their citizenship with responsibility and contributes to the individual and social development of children and adolescents. It is one of the components of the education of citizens.

## V. MAIN TYPES OF PREVENTION:

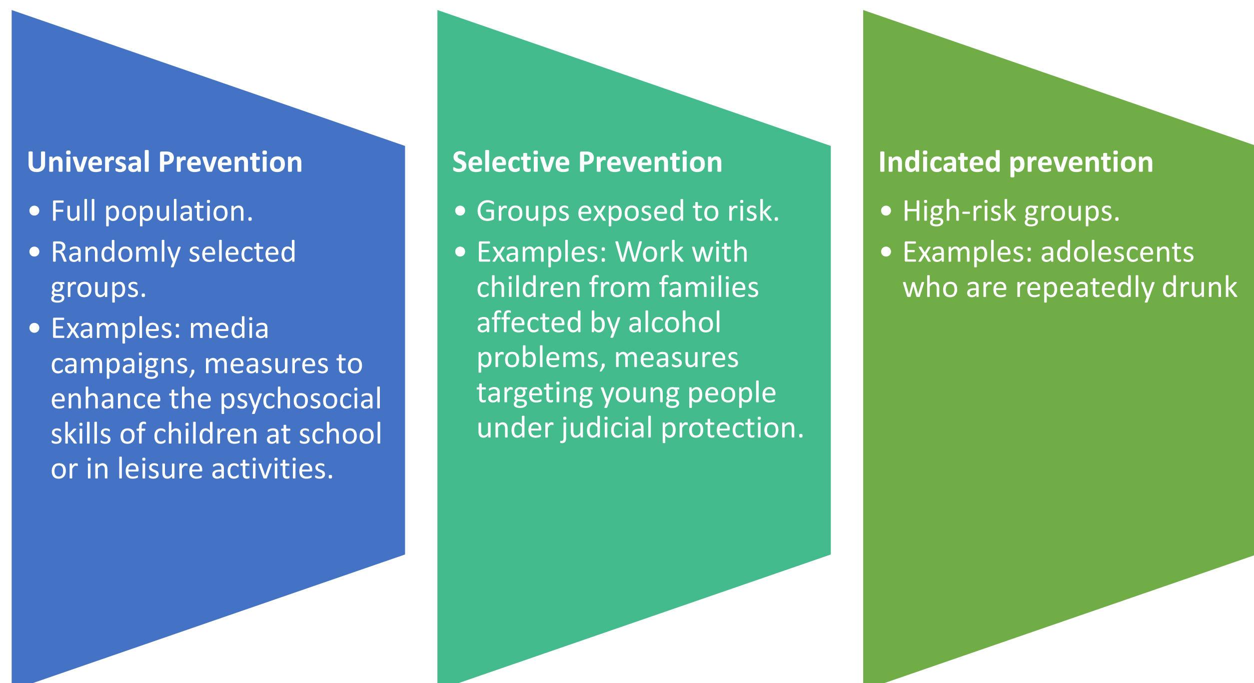
There are two co-existing classifications of prevention, which may complement one another.

The first (WHO, 1984), divides prevention into three categories (primary, secondary and tertiary)




Whereas for a long time the prevailing approach centred on primary, secondary, tertiary and quaternary prevention, this conventional organisation of prevention is now making way for models based on health education and active public participation.

The second classification (Gordon, 1983) divides prevention into three other categories: universal, selective and indicated prevention.



## A. BASIC PRINCIPLES FOR ADDICTION PREVENTION: WHAT ARE THE VALID MODELS?

### V.A.1 **Prevention relates to all ages:**

Prevention must begin at the youngest possible age (from nursery school on) and continue throughout school up to adulthood (25 years of age), through appropriate programmes and approaches designed to develop psychosocial skills and the ability to make informed choices.

### V.A.2 **A progressive approach:**

Notions of addiction and addictive behaviours must be incorporated gradually into prevention measures. Substance types, for example, should be brought up where appropriate, depending on the young person's age and experience. Otherwise, there is a risk of awakening young people's curiosity and creating a desire to experiment.

### V.A.3 **Promoting health and preventive education:**

For prevention to be effective it needs to foster the transmission of social skills and aptitudes enabling the population groups targeted to make the most informed and responsible choices possible. Addiction prevention is built up on the basis of health promotion and preventive education concepts.

#### ***V.A.3.1 The community:***

Prevention is not reserved for prevention professionals.

To be effective and have a long-term impact, it must foster involvement of the people (parents, teachers, youth leaders, politicians, peers, doctors, etc.) in the young person's entourage.

Through a shared concept of prevention, each individual can "play their role as preventers" by contributing to a more favourable environment, responding early and addressing young people's problems.

#### ***V.A.3.2 Peers:***

Prevention through peers can be a useful way of fostering youth participation but it must be overseen by trained professionals to avoid any counter-productive effects.

# VI. SURVEY OF THE CURRENT SITUATION REGARDING ADDICTION PREVENTION IN MOROCCO:

Over the last ten years, Morocco has seen an increasing number of prevention activities, strongly involving various ministries, NGOs and other bodies.

However, addiction prevention policy is still fragmented and sporadic. Prevention measures are still limited for the most part to providing information on products, and there are no true prevention programmes suited to the Moroccan socio-cultural context and no consensus among the various parties involved in prevention.

## A. STRONG POINTS:

- The National Programme for the Prevention and Treatment of Addictive Disorders 2018-2022, shows a real political desire to set up prevention programmes for addictive disorders based on scientific evidence, geared to the Moroccan socio-cultural context.

- There is also major motivation to work in the field of addiction prevention through a wide range of special activities targeting school children.

- A feature of the Moroccan context is the rich and active network of associations. Many NGOs have made it one of their aims to fight drug use in general and/or to prevent the use of psychoactive substances among populations at risk or in vulnerable circumstances such as young people with mental disorders or those that do not attend school or have got involved in crime.

- Specific programmes have been set up by the Population Directorate and the Directorate of Epidemiology and Disease Prevention to promote young people's and adolescents' health and healthy lifestyles, in addition to other strategic programmes and measures designed to combat tobacco and alcohol use.

- Through these programmes, some community-based bodies run by the Ministry of Health and the national education authorities offer psycho-social outreach and counselling services, and health education to promote healthy lifestyles and combat risky behaviour and to provide information and guidance for young people. These bodies include 30 School and University Health Reference Centres, 30 University Medical Centres, 2 university infirmaries and 28 Youth Health Spaces.

- Intersectoral co-operation has made it possible to implement special programmes. For example, the Ulemas' Rabita Al Mohammadia Programme to help young people enhance their know-how and hence avoid risky behaviour (such as violence and psychoactive substance use). This programme has the advantage that it is structured according to age brackets, and material geared to each age group is produced (videos, magazines, video games, stories, etc.).

- Under this programme, the basic training for Ulemas and Morchidates has been enhanced to provide foundations in sociology, psychology and mental health designed to offer better insight into various problem areas including addiction.

- Over the last ten years, the Ministry of Health has run capacity-building programmes for front-line professionals designed in particular to improve early detection and diagnosis of addictive disorders and to introduce brief intervention and motivational interviewing techniques as basic skills for the staff of health establishments.

- The range of addiction prevention and treatment measures on offer has been increased by extending the cover in specialised centres, based primarily on the establishment of multidisciplinary teams involving civil society organisations as key partners of the Ministry of

Health and fostering networking between stakeholders outside the physical confines of these facilities. This is the result of a pragmatic approach adopted by Morocco to deal with the problem of addictions in a holistic manner.

- Further training programmes in addictology have been conducted by the Ministry of Health in recent years and training courses leading to diplomas in addictology can be taken by medical staff. The latter, which were first set up in 2009, are scheduled to be extended to other training centres and other professionals working in the area of prevention and treatment of addictive behaviours.

- In addition, the surveys carried out in schools under the MedSPAD project (Mediterranean School Project on Alcohol and other Drugs; 2006, 2009, 2013 et 2017) reflect a political commitment in Morocco to assessing the problem of drug use in schools and drafting appropriate recommendations to address the problem. MedSPAD surveys analyse information on Moroccan school pupils' knowledge of, attitudes to, opinions about and use of psychoactive substances, focusing in particular on the 15-17 age bracket. They provide precious information about the use of psychoactive substances in this age group and are a means of highlighting behavioural trends linked to long-term use.

- Lastly, the creation and launch in 2014 of the Moroccan Observatory on Drugs and Drug Addiction (OMDA) provides decision-makers with objective, reliable and comparable factual information on drug use and addictions and their consequences. The OMDA is responsible for the scientific aspects and the reliability of reports and publications and for monitoring the data needed for decision making on addiction prevention.

### B. WEAK POINTS:

- Although our knowledge about pupils' use practices has improved over the years, particularly as a result of the MedSPAD surveys, there are gaps in what we know about children's drug use on the street (glue, solvents) and on the use of synthetic drugs (particularly ecstasy).

- Programmes to improve the skills of health professionals and community partners are not provided systematically or over the long term.

- Prevention operatives know very little about theoretical models: either they do not know where to find them or they fear they will not understand them.

- Information and training are not provided for professionals working directly with young people, particularly teachers, educators and sports coaches. These people are in the front line but they do not have the tools to identify young people in difficulty, talk about drugs, recognise worrying situations and refer such cases to the right bodies.

- Public information and information for families and young people, particularly those in vulnerable situations, is not well structured. Efforts are still needed to get the media more involved, set up appropriate conduits for information and co-ordinate the services concerned.

- The role of school health services is still not sufficiently acknowledged and it has become increasingly noticeable that psychoactive substances are available in the vicinity of schools.

- Prevention activities are generally “spontaneous”, one-off and disparate and, in most cases, responses to particular events or crisis situations.

- As to the provision of addiction prevention and treatment, early diagnosis and brief intervention measures are highly inadequate while access to treatment is geographically uneven and geographical coverage is still insufficient in the light of the needs identified by all the stakeholders.

- The approach to partnerships is often inadequate with prevention policy scattered between the various partners involved, meaning that prevention schemes are hampered by the discontinuity of activities, rendering them less effective.

- Lastly, assessments of prevention work and measures based on scientific evidence are rarely carried out, if at all.

# VII. SURVEY OF ADDICTION PREVENTION PRACTITIONERS, SKILLS AND TARGET AUDIENCES IN MOROCCO:

Prevention should be designed for individuals – it calls for their participation and commitment, with due regard for their autonomy, their values and their feelings, while permanently catering for their well-being and their health, along with that of their relatives.

## A. PRACTITIONERS:

### VII.A.1 **Civil society organisations:**

Civil society organisations means associations or groups of associations working in the field of addictions and health promotion, or combating hardship, and associations of patients, users and consumers.

Today, prevention work is mostly carried out by civil society organisations, in the form of unilateral activities, which would benefit from some co-ordination.

### VII.A.2 **Contact professionals (teachers, health professionals, sports coaches and others):**

Training may be offered to contact professionals (teachers, health professionals, sports coaches and others) involved in addiction prevention and counselling activities.

It must enable these professionals to become full addiction prevention operatives, to review their ideas about drug use, drugs and living environments, and to complement their work of caring for and supporting persons in difficulty with their knowledge on addictions.

This approach makes it possible, while showing due regard for the need to prevent occupational hazards, to set up prevention outposts, as part of a risk prevention plan.

### VII.A.3 **Peers:**

Peers are persons with shared characteristics in terms of age, social or cultural background, preferences and prospects.

This peer response approach involves exchanging information and opinions with other people so as to question behaviour, correct misinformation and foster positive attitudes and approaches to health.

It is based on the fact that at some points in life, particularly in a person's youth, the influence of peers is stronger than any other form of influence.

Many campaigns, at school and in recreational settings, make use of peers (young people/students). When it is properly carried out, this interactive strategy is successful both for the target audiences and the peers themselves.

However, it is important to be sure that this interaction is real so as to avoid setting up pseudo-participatory activities calling for the co-operation of young people only occasionally and incidentally.

### VII.A.4 **Religious leaders (Imams and Mourchidates):**

Religious leaders are currently trained in mental health and addictology during their training. Having acquired the necessary skills, they could play a key role in preventing addiction through their advice and their sermons.

## B. PSYCHOACTIVE SUBSTANCE USE PREVENTION WORKERS – PROFESSIONAL SKILLS AND PROFILES

### VII.B.1 **Addiction prevention workers:**

The profession of addiction prevention worker is not controlled by any regulations in Morocco. There are no rules concerning a minimum age or a qualification required to engage in it. It would be desirable for such workers to be required to have a recognised qualification.

Psychoactive substance use prevention workers may exercise in the public, private, voluntary or any other sector, in a rural or urban setting and at various times (after school or outside school).

In this connection, addiction prevention workers must acquire skills in the prevention of addictive behaviours so as to be able to respond to situations on the ground.

Such workers are not expected to be specialists in addictive behaviours. They just need to be trained so that this issue can be incorporated into their educational functions and they know how to respond appropriately to young people's needs in this area or, where necessary, refer them to the most suitable support facilities.

Besides leading and supervising groups of young people prone to problems of behaviour and addiction, such workers must also deal with issues linked to their life in the community. They must be properly prepared to cope with this. They must also understand and accept the fact that they

will be working with an integrated, multidisciplinary team, drawing on shared expertise and complementary skills.

Addiction prevention workers must use data validated by the scientific community and high-quality working materials.

Their tasks are multiple and varied and relate to the design, development, installation, running and assessment of prevention, awareness-raising and training tools and campaigns, targeting highly diverse groups and young people in particular.

Some recommendations to make addiction prevention campaigns successful:

- Adopt an approach based on health promotion;
- Take a long-term view;
- Avoid just passing on knowledge; pursue other aims such as changing outlooks and helping participants acquire new skills;
- Aim to develop psychosocial skills;
- Involve target audiences in the preparation, implementation and assessment of the project;
- Incorporate a notion of positive health into activities;
- Avoid using fear as a lever;
- Do not judge or stigmatise groups or make them feel guilty;
- Cater for target groups' viewpoints, experiences and needs;
- Acknowledge the benefits of psychoactive substance use;
- Provide objective, scientifically endorsed information;
- Include activities in the project which strengthen the participants' capacity to act;
- Favour interactive methods fostering active participation;
- Include an identification and guidance mechanism: help participants to access treatment.

### VII.B.2 **The educational approach of addiction prevention workers:**

It is also important to highlight the educational approach that prevention workers should adopt. Prevention workers are often viewed as role models by the target audience, who will seek to identify with them. Workers are often very close to the target audience, in terms both of age and of centres of interest.

Workers have a duty to pay attention to the messages and images they may convey, not only through their words but also through their own behaviour.
Their approach must be ethical and exemplary, both in their attitudes and in their words. They should also refuse to engage in any activity which does not form part of the predetermined action plan.

They must be highly proficient at oral communication and have the required knowledge to devise prevention activities which meet the needs of the target populations at school and in the community.

An excellent command of the three core aptitudes is essential, beginning with knowledge of the facts, particularly those concerning the most commonly used drugs in Morocco and the prevention models recommended by this national reference guide, which is based on best practices. Second comes their life skills, meaning their attitude, self-knowledge, talents as a facilitator and ability to

adapt to their audience and, lastly, their know-how, which calls for proficient use of the tools and techniques they will deploy based on the factual information available.

Prevention workers must also show a degree of creativity that enables them to adapt to circumstances and use the resources at their disposal wisely.

Their words, clothes and body language must reflect their respect for their audience. They must use simple, clear language and modulate their voice with the appropriate inflections.

They should also have a collection of activities to break the ice, helping participants to get to know one another and feel at ease together, and energising activities using short and amusing games to raise energy levels and retain their audience's interest.

Lastly, workers should manage group dynamics so as to prevent one or two people from dominating discussions and uphold discipline in a flexible manner, particularly vis-à-vis fractious group members.

### C. THE ROLE OF PREVENTION TOOLS:

During activities devoted to addiction prevention it is essential to present various tools which will make it possible, during activities with future prevention workers:

- to get the group thinking through reference to concrete circumstances and various use scenarios;
- to provide an educational dimension (through multimedia tools, films, leaflets and games);
- to put a long-term prevention project into practice with a target audience (raising a group's awareness, involving the entire team and management, creating a prevention tool with a group).

The prevention tools recommended in this guide come from the European drug addiction prevention programme, Unplugged.

For the Moroccan context, the guide proposes the Unplugged prevention model, which brings together a list of characteristics which research workers and practitioners have identified as determinants among young people (particularly at school), drawing in particular on a comprehensive social influence model, combining life skills and placing the emphasis on setting standards and young people giving an undertaking not to take drugs.

UNPLUGGED is a school and community drug prevention programme targeting 12 to 16-year-olds, drawing on a comprehensive social influence approach. It was devised, implemented and assessed over the course of a multi-centre survey in seven European countries.

It is worth pointing out that tools should not be served up ready made; instead the emphasis should be on target audiences appropriating tools for themselves.

## D. PSYCHOSOCIAL SKILLS:

According to the World Health Organization, psychosocial or life skills are the ability of an individual to deal with the demands and challenges of everyday life.

They also encompass a person's ability to maintain a state of mental well-being, adopting appropriate and positive behaviour when interacting with others and their culture and environment.

They have a particularly important part to play in promoting health in its broadest sense.

When health problems are related to behaviour and this behaviour stems from an inability to deal effectively with stresses and pressures in life, enhancing psychosocial skills can be an influential means of promoting health and well-being, especially at a time when behaviour is increasingly implicated as a source of health problems.

These resources from everyday life are divided into three main categories: social, cognitive and emotional skills.

### Social skills (or interpersonal and communication skills)

**Verbal and non-verbal communication skills:** active listening, expressing feelings, ability to give and receive feedback.
**Empathy**, i.e. the ability to listen, understand another's needs and views and express that understanding.
**Negotiation/refusal skills:** conflict management, assertiveness skills, refusal skills (ability to resist pressure from others).
**Co-operation and teamwork skills.**
**Advocacy skills,** based on persuasion and influencing skills.

### Cognitive skills

**Decision-making** and problem-solving skills.
**Critical-thinking and self-appraisal,** involving the ability to be able to analyse peer and media influences, to be aware of the values, attitudes, norms, beliefs and factors affecting us and to identify relevant information and sources of information.

### Emotional skills

**Skills for managing feelings:** anger and anxiety management, ability to cope with loss, abuse and trauma.
**Skills for managing stress**, involving time management, positive thinking and relaxation techniques.
**Self-appraisal and self-management skills**, fostering confidence and self-esteem.

The above list is not exhaustive; it can be fleshed out through exchanges with the target group.

Building up psychosocial skills from the youngest age makes it possible to prevent problems linked to psychoactive substance use, violent conduct, risky sexual behaviour or mental health problems.

The aim is to enhance skills "to act for" rather than to "fight against".

### E. TARGET AUDIENCES:

- **12 to 16-year-old children at school;**
- **12 to 16-year-old children in the community and in associations (youth clubs, etc.);**
- **Parents and family (at school and in the community).**

# VIII. RECOMMENDATIONS FOR THE IMPLEMENTATION OF AN ADDICTION PREVENTION PROJECT

## A. THEORETICAL FRAMEWORK AND PRACTICAL TOOLS:

### VIII.A.1 The theoretical framework for young people

The main aim of psychoactive substance use prevention is to help people, especially young people, avoid or delay being initiated in the use of such psychoactive substances or, if they have already begun, to avoid the onset of use-related disorders resulting in a harmful dependence.

The general aim of drug use prevention, is much broader however. The goal is to foster the safe and healthy development of children and young people enabling them to fulfil their talents and their potential and become useful and responsible members of their community and society. Effective prevention makes a significant contribution to the positive commitment of children, young people and adults to their family, school, workplace and community.

Every child is unique and his/her development is influenced by a series of personal, socio-economic and cultural factors. As a general yardstick, the following aspects can be taken into account when determining age ranges: early childhood covers preschool children aged 0 to 5; middle-years childhood covers children at primary school aged 6 to 10; early adolescence covers children aged 11 to 14; adolescence covers the age from 15 to 18 or 19; and this is followed by adulthood from the age of 18 or 19 onwards.

The following measures are recommended, depending on the settings in which they are applied, the target groups or populations involved and the operatives trained specifically to implement them:

1. At school: measures provided by teachers, sports coaches and civil society organisations (CSOs)
   - For children aged 12 to 16
   - Mentoring is recommended as a proven measure to prevent drug use and violence among young people and should be provided by adults with a good understanding of child psychology and a genuine concern for children’s well-being.

2. In a community setting: measures provided by nurses, midwives, CSOs and social workers
   - For pregnant women: brief interventions intended to protect the physical and mental health of pregnant women and the children they are carrying
   - For young mothers: brief interventions and counselling by CSOs and social workers to equip mothers with the skills to be good parents and enable them to look after and protect their young children better.

3. In a community setting: measures provided by CSOs, sports coaches, religious leaders and others

- For young people: mentoring; in leisure venues: by CSOs
- For parents: by CSOs
- For women: by CSOs, women's associations and associations promoting the well-being of women and families.

4. Sports for prevention: provided by sports coaches and CSOs for young people practising any type of sport at school or in the community

5. Social networks for prevention targeting young people via Facebook, Twitter, WhatsApp, Instagram, etc.

### VIII.A.2 **Practical tools for young people**

UNPLUGGED is based on a comprehensive social influence model, which is interactive and includes aspects of life skills training and correction of normative beliefs. The target group is children aged 12 to 14 because this is the age at which some children begin experimenting with drugs (particularly tobacco, alcohol and cannabis). The programme is intended to reduce drug use initiation and/or to delay the transition from experimental to regular use. It is made up of 12 weekly 60-minute lessons, meaning that the programme spans 12 weeks in total. It is based on three pillars, namely information and attitudes, interpersonal skills and intrapersonal skills.

The everyday life skills tied up with drug prevention are linked to social relations or behaviours, such as establishing a connection with unknown persons and the ability to listen carefully. These are social, emotional or personal skills.

The reference models for this programme are linked to the interpersonal and intrapersonal life skills of being able to appreciate and respect others and establish positive relations with family and friends, listening and communicating effectively, trusting others and shouldering responsibilities.

It is understood that life skills can differ from one culture to another and from one setting to another. However, research suggests that a set of basic skills lies at the heart of schemes to promote the health and well-being of children and adolescents. Normative beliefs also play a key role in drug prevention.

## B. THE THEORETICAL FRAMEWORK FOR PARENTS AND FAMILIES

The role of parents and families is to protect children and young people, to foster their healthy development and to instil within them the ability to control their emotions and their social interactions and prevent the use of psychoactive substances.

A lack of knowledge about psychoactive substances and the consequences of their use are among the factors which increase a person's vulnerability. Other factors are genetic predisposition, personality traits such as impulsiveness and a desire for strong sensations, mental disorders or behaviours, parental negligence or abuse, a lack of attachment to school or the community, social norms and an environment conducive to drug use.

Conversely, psychological and emotional well-being, personal and social skills, firm ties with good parents and a strong attachment to a well-organised and resource-rich school and community are factors which reduce a person's vulnerability to drug use and other risky behaviours.

Supporting and supervising parents and families to help them develop or improve parental skills are key to bringing up children who are in good physical and mental health and to preventing problems linked to adolescence later on.

Parents face a plethora of challenges where it comes to meeting their families' needs. Striking the delicate balance between family and work, money issues, social obligations and creating a convivial space with children is often very difficult. Factors such as a lack of trust and warmth in parent-child relations and a lack of security, structure and discipline within the family unit give rise to the risk of behavioural and mental health problems and subsequent drug use.

Programmes to improve family skills have proved very successful in preventing a number of child behavioural problems including those linked to drug use. Research has confirmed that programmes to build up these skills are far more effective than simply providing parents with information, and they can be implemented from early childhood up to adolescence, perpetuating fundamental positive changes in the functioning of families and parental skills.

Families can act both as protective factors and as risk factors where drug use is concerned. Although genetic and environmental factors help to shape the development of children and young people, family dynamics play a very important protective role.

Studies on prevention show that the risks that children will use psychoactive substances later in life are influenced by the consumption of cigarettes, alcohol and drugs during pregnancy. Such consumption poses a serious threat to the health of the woman and the baby even if the woman does not suffer from disorders linked to drug use. Midwives or nurses must inform pregnant women about these risks and their impact on the normal, healthy development of the foetus. Women suffering from disorders related to drug use must be referred to the appropriate treatment facilities.

The World Health Organization recommends that health professionals request information from pregnant women on their use of tobacco, alcohol and drugs and offer any pregnant woman who is consuming alcohol or drugs a brief intervention to help her to stop.

All the research on methods to be used agrees on a number of points. Other research on resilience has made it possible to identify the crucial family factors which help to protect children from drug addiction. They concur on a number of essential aspects, which are as follows:

(a) Safe and healthy attachment between parents and children;
(b) Parental supervision and effective discipline;
(c) Communication of prosocial and family values;
(d) Involvement of parents in their child's life;
(e) Parental support for children and young people (emotional, cognitive, social and financial).

Children and families who experience acute or chronic stressful events report that parenting and family factors help young people to surmount harmful family situations and achieve positive results. Research shows that parents who support and encourage their children to become independent,

expect rules to be obeyed and follow coherent and fair rules in their disciplinary practices have children who are more resilient than others.

Other factors which contribute to resilience are an organised, balanced family environment, supportive relationships, family beliefs, family cohesion, and problem-solving, coping and communication skills. Research provides sound evidence that parents and families can be powerful protective factors in the life of children and young people.

Conversely, research also provides evidence that parent-child relationships and families characterised by indifference, unresponsiveness, emotional insecurity and inconsistency on the part of parents in the way that they support and comfort children during the first years of their development are associated with risks of depression, anxiety and relationship problems in childhood and adulthood.

The main family factors which expose children and young people to risks of drug use are: (a) a lack of ties and insecure relations with parents; (b) the absence of a caring relationship with a caring adult; (c) insufficient parental involvement; (d) a chaotic household.

Training in family skills is generally designed to reinforce the protective role of families. It may incorporate exercises intended to increase communication, trust, and problem-solving and conflict-resolution skills. It may also include opportunities for parents and children to spend positive time together, as a means of strengthening ties between parents and children.

To provide the protection and tackle the risks described, family skills training programmes generally include strategies to enhance: (a) positive family relationships; (b) discreet supervision of children or young people; (c) the communication of family values and expectations.

#### VIII.B.1 **Practical tools for parents and families**

(Refer to the factsheets below, appended to this guide in the form of PPT slides, which will be used during the training sessions).

# IX. ADDICTION PREVENTION MODELS CHOSEN FOR THE MOROCCAN CONTEXT

## A. FOR YOUNG PEOPLE

#### IX.A.1 **The Unplugged model.**

## B. FOR PARENTS AND FAMILIES

A proper family skills programme is based on a number of principles taking into account the evidence and good practices mentioned above:

**Principle 1.** A proper prevention programme for parents will be based on a robust theory designed to prevent problem behaviour by addressing the fundamental causes of such behaviour at an early stage and altering it.

**Principle 2.** The programme will also draw on an assessment of parents' needs to understand more about their situation in terms of family risk and protection factors and to inform the appropriate choice.

**Principle 3.** It must properly address the level of risk among both the general population (universal protection) and families considered to be at risk (selective programmes).

**Principle 4.** It must specifically meet parents' training needs in accordance with their children's' age and level of development.

**Principle 5.** The programme must be sufficiently long and intensive.
It is crucial to plan enough training sessions to give parents an opportunity to practise the skills intended to bring about a change in behaviour.

For universal programmes, four to eight sessions are enough because families among the general population are exposed to fewer risk factors and can change more easily.

As to the selective programmes for high-risk families, 8 to 12 sessions need to be planned including booster lessons. The higher the number of risk factors, the longer is required to build trust, influence and change behaviour, and provide psychological and, if possible, socio-economic support.

Each training session lasts two hours.

**Principle 6.** Sessions must be interactive.
Activities are held with groups of 8 to 12 families. Providing information on family skills and discussing them is not enough; evidence-based family skills training programmes must use interactive techniques to give parents and families means of putting the skills acquired during sessions into practice. Experimenting at home is another key interactive technique. For this purpose, the number of families at each session should be kept to a minimum. It is difficult to be prescriptive about this, but the ideal number of families within a group will vary between eight and twelve.

**Principle 7.** It must provide parents with the necessary skills and opportunities to enhance positive family ties and the management and supervision of the family and help them to pass on family values and expectations.

Although parental skills training programmes vary considerably, they are based on a relatively common understanding of family risk and protection factors and therefore comprise many shared basic features and skills.

Essential content and parenting skills taught include the ability to be receptive to children. Parents must learn and practise how:

a) to show affection and empathy towards one another, their children and others;
b) to confer positive attention and praise on a form of desirable conduct which has been clearly communicated to the child;
c) to express their own feelings and emotions appropriately, talk about their children's feelings and emotions and help their children to acknowledge them;
d) to identify and model a form of behaviour corresponding to the values and standards they wish to pass on to their children;

e) to learn new coping, resilience and anger management skills to avoid other stresses, use fair strategies and eliminate verbal and physical attacks;
f) to apply responsive play skills, allowing children to lead play and deal with other children.

**Principle 8.** It must be adjusted to accommodate the cultural and socio-economic values of the target population through a well established system. The adaptation process must be systematic and carefully planned so as to balance the community's needs with the need to remain faithful to an original programme which has been assessed and found to be efficient.

# X. PREVENTION TOOLS: FACTSHEETS

Practical factsheets have been drawn up on the basis of best practice models for prevention, international UN reference documents and other globally recognised expert bodies. They were devised with due regard for Moroccan society's specific social, cultural and religious features.

## A. PREVENTION TOOLS FOR YOUNG PEOPLE.

The European Union's Unplugged prevention model has been a key tool in the prevention of psychoactive substance use, particularly among school pupils. The fact sheets are made up of 12 sets of PowerPoint slides which serve as technical support materials for instructors. It should be stressed that instructors will receive prior training on the use of Unplugged in Morocco because there is a very specific interactive methodology for its implementation.

The 12 lessons are as follows:

Lesson 1 Opening Unplugged
Lesson 2 To be or not to be in a group
Lesson 3 Choices – Alcohol, Risk and Protection
Lesson 4 Your beliefs, norms and information – do they reflect reality?
Lesson 5 Smoking the cigarette drug – Inform yourself
Lesson 6 Express yourself
Lesson 7 Get up, stand up
Lesson 8 Party tiger
Lesson 9 Drugs - Get informed
Lesson 10 Coping competences
Lesson 11 Problem solving and decision making
Lesson 12 Goal setting

Teachers will be trained so as to be able to implement the programme properly. They will have 12 factsheets available to them, one for each lesson, which will be in the form of a PowerPoint so as to facilitate their task.

The 12 Unplugged PowerPoint factsheets are appended hereto.

### B. PREVENTION TOOLS FOR PARENTS AND FAMILIES.

As to prevention tools for parents and families, this National Guide favours a model based on a number of prevention programmes for this population group, which have been implemented in various cultural contexts and thoroughly assessed.

## XI. QUALITY CONTROL ASSESSMENTS / PREVENTION PROGRAMMES

### A. FOR YOUNG PEOPLE

Assessment of the Unplugged programme will be based on a pre-test and post-test questionnaire, which has been validated. The pre-test will be conducted one week before the first lesson whereas the post-test will be carried out after the end of the 12-week programme, then again, one year after the beginning. The assessment protocol will be discussed with the Moroccan authorities before being finalised.

### B. FOR PARENTS AND FAMILIES

#### XI.B.1 **Brief interventions (for trainers/facilitators)**

Brief interventions are an ideal small-scale prevention method for adolescents and adults. They consist of one or more sessions of one-to-one counselling conducted by appropriately trained health staff and social workers for persons who may be at risk but do not necessarily require treatment.

Sessions are structured and last 5 to 15 minutes. They begin by establishing whether there is a problem of psychoactive substance use and immediately offer basic counselling and a referral for treatment if this is called for.

Brief interventions are normally dispensed in primary health care centres but are also effective on emergency wards and in informal non-health settings such as voluntary community or civil society organisations, schools or workplaces.

Brief interventions are based on motivational interviewing techniques in which the person's use of psychoactive substance use is discussed. Participants are encouraged to take decisions for their well-being and draw up a work plan with well-defined goals to solve their drug problem. In such cases, brief interventions are conducted over a maximum of four sessions each lasting 30 minutes to one hour.

CSOs with training on drug use prevention or addictive behaviours are rare, although some of these non-governmental organisations work in this field. There is also a dearth of training materials and guides for the implementation of specific programmes in this area. A practical guide for persons working with young and at-risk persons, whether health professionals or members of associations, will provide them with tools and precise guidance on the implementation of coherent psychoactive substance use prevention programmes among young people, particularly those in vulnerable situations such as street children, young people in conflict with the law and other offenders.

The following prevention measures are recommended for pregnant women:

### XI.B.2 Pregnant women

It has been scientifically proven that the consumption of alcohol, nicotine and drugs during pregnancy has a negative effect on developing embryos and foetuses.
Antenatal consultations are ideal times to educate pregnant women about the dangers of psychoactive substance use for their own health and that of the baby they are carrying during pregnancy and later on during the child's life.

Recommended measure: Brief intervention using the SBIRT approach, which consists in:

- Screening (S)
- A brief intervention of 5 to 10 minutes (BI)
- Where needed, referral to treatment (RT)
- Operatives: Health staff and social workers in the community.

A PowerPoint factsheet on brief intervention is attached.

### XI.B.3 Young mothers

During the early stages of their development, infants interact with their parents and above all with their mother. If the mother lacks parental skills and/or suffers from other difficulties linked to poor health, financial problems or other difficulties, particularly in a marginalised socio-economic setting or a dysfunctional family environment, she must be supported.

Recommended measure: Training in parental skills

Operatives: Doctors and/or nurses at hospital and social workers in the community.

### XI.B.4 Parents

**Preliminary module.** Introduction (for trainers, facilitators and operatives only)

**Module 1.** Understand the drugs used in the Moroccan context (cigarettes, alcohol, cannabis, heroin, and stimulants including cocaine, amphetamines and ecstasy). Their harmful effects on health.

**Module 2**. How to give your child a feeling of security

- Create a safe, peaceful, harmonious and caring environment in the home.
- Foster a safe and healthy attachment between parent and child.
- Establish discreet parental supervision and effective discipline.
- Do not shout or yell at your children.
- Parents should not argue in front of their children.

**Module 3.** Communication and dialogue.

- Communicate actively.
- Listen to your children carefully: Devote yourselves entirely to them when you are together. (Put away your laptop; stop reading your newspaper; do not watch your television or look at your iPad).
- Passing on prosocial and family values.
- Show warmth towards them.
- Show interest in what they are doing.

- Take pleasure in taking part in activities with your child.
- Play and be happy together. (Play football or practise another sport together).
- Encourage them regularly. Congratulate them on their efforts and their achievements, however small.

**Module 4.** Establish family discipline and house rules

- Be a good role model for your child and encourage good behaviour.
- Instil a sense of discipline within children. Children and young people are not adults. Their brains are still developing.
- Children need to know what the rules in their family are and learn not to break them.
- Establish clear and reasonable rules and review them as children grow up.
- Discuss the rules with children and the consequences if they are broken. Avoid overreaction and do not impose punishments that you cannot apply.
- Consequences should be proportionate to the seriousness of the breach of the rules.
- Be firm about psychoactive substance use. Protect your child from drug use and other harmful forms of behaviour.
- Do not allow yourself to be carried away by your emotions. Avoid negative or emotional reactions.
- Strike a balance between supervising your child's behaviour and his/her progression towards autonomy.
- Show your child that you also impose limits on yourself.
- Choose your battles. Is it really worth quarrelling over trifling matters?

**Module 5.** Parental support (emotional, cognitive, social and financial).

- Support children to help them complete difficult tasks and reach objectives.
- Guide them in difficult situations.
- Help them to acquire problem-solving skills.
- Provide children with the information and practical assistance needed to solve problems.
- Provide money to pay for important needs having had a proper conversation with the child and analysed the situation appropriately.

**Module 6.** Teach parents how to manage their stress using the Qi Gong method.

1. *The Qi Gong method*

Very often parents suffer stress from multiple sources which prevents them from managing their lives. One major source of stress is the situations and difficulties faced by their children. An effective means of alleviating stress is the Qi Gong method.

In the Qi Gong philosophy, Qi means subtle breathing or life energy and Gong is a skill nurtured through constant practice.

Qi Gong is an ancient Chinese practice which has been developed and used in China over the last 7 000 years to prevent illness and improve physical condition. Concentration, relaxation, meditation, regulation of breathing, posture and body movements are the basic components of Qi Gong and are designed to achieve a harmonious flow within the body and cultivate a pattern of regular exercise and training to improve people's physical condition and general well-being through the co-ordination of rhythmic movements, regulated breathing and meditation.

Qi Gong can be described as a practice which improves physical and mental health through techniques focusing on posture, movement, breathing techniques, self-massage, sound and focused attention.

This practical guide recommends that the method is applied sparingly, for 10 to 15 minutes per day, and points out that practising it can bring about considerable physical and mental well-being (video demonstration included).

### XI.B.5 **Families**

The family is the unit comprising parents and children or young people. The following two modules are joint interactive sessions bringing together parents and young people and designed firstly to discourage parental approaches and methods using coercion and secondly to improve communication between parents and young people. The two modules partly reproduce components of modules 3 and 5 above, on parents.

**Module 7** (for families). Make better use of protective family ties to alleviate peer pressure.

- Support children to help them complete difficult tasks and reach objectives.
- Guide them in difficult situations.
- Help them to acquire problem-solving skills.
- Provide them with the practical assistance needed to solve problems.
- Plan and organise joint family activities together.
- Apply disciplinary measures that are proportionate to the seriousness of the breach of the established rules and the child's level of development.
- Calmly discuss difficult subjects such as psychoactive substance use, interpersonal relations and sexuality.

**Module 8** (for families). Foster communication and dialogue between parents and children and solve problems together. During the session, families and hence parents and children will learn and practice together how:

- to listen carefully to one another;
- to pass on shared family and prosocial values and learn to respect them;
- to discuss major problems and solve them together;
- to reach a consensus on how tasks are to be divided up among family members;
- to provide respectful and appropriate feedback on each other's activities.

This National Guide recommends that all psychoactive substance use prevention activities should be supervised using a thorough system of monitoring and assessment. This will ultimately make it possible to highlight the relevance of such activities and their effectiveness.

Assessment of the Unplugged activities for young people will be based on a questionnaire to be submitted to participants. A pre-test before implementation will be followed by a post-test using the same questionnaire after the twelve weeks of the programme. A second post-test will be taken by the same participants 9 to 12 months after the end of the programme. A control group comprising the same number of young people with an identical profile to that of the actual participants could also take the pre-test and the post-test.